

# **Medication-Assisted Recovery: Medication Assisted Peer Recovery Support Services Meeting**

**September 28, 2015  
Summary Report**

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Support Services Meeting  
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**U.S. Department of Health and Human Services**

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Division of Pharmacologic Therapies

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# **I. Medication-assisted Peer Recovery Support Services Meeting Purpose and Background**

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) convened a meeting with the purpose of identifying the opportunities and challenges that peer recovery support services (PRSS) provide to Opioid Treatment Programs (OTPs). The meeting agenda was designed to gather stakeholder perspectives about facilitators and barriers to expanding PRSS, to share information about PRSS models, and to generate ideas for incorporating PRSS into OTP settings. A total of 30 participants were invited by SAMHSA/CSAT to attend the meeting. Participants included members of organizations at community and state levels, including providers, administrators, policy-makers, peer advocates, persons with lived medication-assisted treatment and recovery experience, and experts in funding and implementation in treatment and recovery programs. A roster of meeting attendees is included as Appendix A.

Following an introduction by Wilma Townsend, Team Leader at the Division of Pharmacologic Therapies (DPT) at CSAT, opening remarks were made by Robert Lubran, Director of DPT. Mr. Lubran gave a brief history of SAMHSA's role in the Federal oversight of CSAT/SAMHSA throughout all OTPs. Mr. Lubran also provided an overview of the regulatory function including oversight, accreditation, and guidance to programs to ensure they are aligned with SAMHSA guidelines and have effective outcomes. He briefly summarized how PRSS fit into the treatment and recovery continuum. Revised OTP guidelines released by SAMHSA this year include emphasis on implementing a recovery orientation throughout all services.

Mr. Lubran concluded by noting it was important for participants to advocate to SAMHSA to prioritize the inclusion of PRSS in OTPs, as a strategy to align medication-assisted recovery (MAR) with medication-assisted treatment (MAT). The next steps for supporting this fully realized recovery-orientation will require an understanding that:

- MAT is an evidence-based practice (EBP) shown to reduce use and mortality, and improve outcomes,
- MAT remains controversial, despite supportive evidence, largely based on misunderstandings and ignorance about the use of medication and its relationship to "abstinence-based" recovery, and
- Funding mechanisms for PRSS need to be better researched, understood, and promoted.

Mr. Lubran encouraged meeting participants to use the meeting to emphasize and heighten MAT as a valid pathway to recovery, as well as to address ways to move the issues forward.

Meeting participants introduced themselves and shared their reasons for participating in the meeting. Their introductions conveyed personal and professional experience and leadership in the field and included what they would like to see as meeting outcomes:

- To develop a shared understanding of the effectiveness of PRSS and their application to MAT/MAR,

- To have learnings and information to share with respective organizations and communities, and
- To develop an action agenda to:
  - integrate PRSS programs with OTPs,
  - demonstrate the value of PRSS to MAT clinical and support staff,
  - get services funded through Medicaid, state and local funds, private funds, and use of current federal grants,
  - advocate for peer PRSS,
  - start the conversation with other organizations and stakeholders about peer recovery support services,
  - educate families about stigma and to understand the need for MAT therapies and peer services,
  - document and disseminate best practices of successful PRSS integration in OTPs.

In the following segment, participants were asked identify opportunities, challenges, and next steps to develop and integrate PRSS in coordination with OTPs. This began with an overview of PRSS, followed by small group discussions that detailed the value of PRSS to individuals, families, communities, and organizations; challenges of aligning PRSS with OTPs; and strategies to increase the numbers of OTPs offering PRSS programs. This meeting summary report synthesizes the day's discussions along two broad themes: the development of PRSS programs as they currently exist and recommended actions toward implementing a recovery orientation in systems, services, and supports.

## II. Review of Current State of Peer Recovery Support Services

It is important to note that there are different ways of incorporating peer recovery support services into OTPs. One way is to hire, as employees, a certified peer recovery coaches these are individuals trained and qualified to provide this service, with the value of having lived experience of both addiction and recovery. Lived experience has proven to be a key bonding factor that allows for patients to feel comfortable with and connected to someone who understands their strengths and needs, challenges, and aspirations. Reimbursement for these positions (it is always recommended to create two or more peer staff positions) are available in some states: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf>.

An alternate way to approach peer services in an OTP is to set up a *peer program*, as highlighted in this report on a presentation by the MARS (Medication-Assisted Recovery Services) Project. Developing a peer program is a more sustainable option in that it allows for peers to have direct input in the services, engenders a sense of peer ownership, fosters cooperative and collaborative autonomy, and effectively creates a culture of recovery, both in the program and in the OTP.

Developing a peer program will also help to engage patients beyond one-on-one coaching through peer-facilitated support and educational groups, linkages to instrumental supports such as employment and housing, and activities that support community connection and belonging.

MARS has designed a replication project called Beyond MARS that can give guidance to setting up a peer program in an OTP. (<https://vtrecoverynetwork.org/solutions.html>) Alternately, OTPs may consider setting up a mutual agreement to contract recovery community organization (RCO), described as, “organizations that are independent, non-profit, led and governed by people in recovery, family members, friends and allies mobilizing resources within and outside of the recovery community...” Many RCOs have developed PRSS programs and recovery community centers, some of which include programs specifically geared to MAT patients (i.e., Vermont Recovery Network). Others may not be MAT-specific, but have valuable PRSS program experience that could benefit OTPs in design and implementation. For more information on RCOs:

<http://www.facesandvoicesofrecovery.org/sites/default/files/resources/7.13.15%20FINAL%20Recovery%20Community%20Organization%20Toolkit.pdf> and <http://www.facesandvoicesofrecovery.org/who/arco>

## **A. Overview of the PRSS Programs in OTPs**

Prior to the small group discussions, an orientation presentation provided additional context and outlined several concepts upon which PRSS programs are based. Walter Ginter, Director of Medication-Assisted Recovery Services (MARS), provided a definition of PRSS, as well as an overview of how it operates in conjunction with treatment services and recovery community supports. Mr. Ginter’s presentation covered the biology and brain science of addiction, as well as the various treatments available including the medical model, mental health programs, therapeutic communities, faith-based initiatives, and efforts within the criminal justice system. He also emphasized the stigma of addiction and recovery, specifically MAR, and offered that the stigma carries over to MAT clinical and support staff, a great majority of whom do not have personal lived experience as MAT patients or family members.

Mr. Ginter shared a holistic definition of recovery and recovery concepts, emphasizing that recovery is an ongoing process and that individuals need to have an active role in owning their recovery. As part of both treatment and recovery efforts, Mr. Ginter discussed how the MARS project provides peer support and information about medication, addiction, and recovery through the use of trained Peer Recovery Coaches. [Individuals functioning in this type of role are also referred to as a Peer Support Specialist, Peer Coach, Recovery Coach, Peer Support Worker, Peer Recovery Specialist, and other names—there is variation in the name of the role across different programs.] MARS is a peer-driven PRSS project sponsored by the National Alliance of Medication Assisted (NAMA) Recovery. MARS provides core training to medication-assisted clients on topics such as methadone as a medication, addiction as a brain disease, and exploration of “What is recovery?”

Mr. Ginter shared the recent evolution of MAR as a compliment to MAT. This is a fairly new and emerging concept, as MAT patients have been traditionally discouraged from forming

relationships with other patients, thus thwarting any connection to recovery and community. This is a paradigm shift in both MAT and recovery community cultures: that medication-assisted recovery is a real, valuable, and viable pathway to recovery. The proliferation and flourishing of PRSS in relationship to OTPs can be seen as a strategy to create institutional support to develop, nurture, and advance MAR.

## ***B. Considerations for Implementing Peer Recovery Support Services in OTPs***

Three additional presentations, summarized below, outlined various factors and elements for consideration.

### **Medicaid Reimbursement of Peer Recovery Support Services**

Gina Eckart, from Health Management Associates in Indianapolis, spoke about Medicaid funding for peer recovery support services. There are several vehicles through which Medicaid reimburses these services, including 1905(a), 1915(b), 1915(c), 1915i, Section 2703 Health homes, 1115 Authority, and Certified Community Behavioral Health Clinic (CCBHC) Demonstration waivers. Ms. Eckart also discussed the guidance that the Center for Medicare and Medicaid Services (CMS) provided to states interested in offering peer recovery support services in a letter to Medicaid Directors, dated August 15, 2007. The letter served to allow the provision of peer services as part of a comprehensive mental and substance use disorder service delivery option, detailing who can provide the services, as well as supervision and training requirements.

Ms. Eckart also highlighted states that had been successful in implementing peer recovery support services using a variety of funding strategies, including:

#### **Community Examples:**

- Massachusetts Department of Health, Bureau of Substance Abuse Services funded a network of peer recovery support centers through state, federal block grant, Medicaid, and HMO funding by effectively establishing a business case through consideration of relative benefits and risks involved in investing in peer recovery support services,
- In Arizona, Community Bridges Inc., a nonprofit treatment and recovery services organization, is funded through a variety of sources including SAMHSA, the Arizona Department of Economic Security, the Arizona Department of Health Services, Housing and Development, Valley of the Sun United Way, the Governor's Office for Children, Youth and Families, the Veteran's Administration, the Maricopa County Justice Court and the Cities of Mesa, Tempe, Scottsdale, Chandler, Avondale and Gilbert. It employs 300 peer leaders in programs which include prevention, education, and treatment services. Contracts are held with regional behavioral health authorities.

#### **Certified Individuals Examples:**



- Georgia integrated Medicaid-funded behavioral health peer services by adding an addiction recovery component to a pre-existing mental health Peer Support Specialist role, creating the Certified Addiction Recovery Empowerment Specialist (CARES) position. Indiana Division of Mental Health and Addiction and Department of Health: jointly approved a training and certification process for a peer specialist position called the Care Community Worker (CCW).

Ms. Eckart summarized some of the challenges in the reimbursement of PRSS, including maintaining an authentic peer recovery role, gaining acceptance by clinicians, diversified funding, outcomes data, training and supervision of peers, advocacy, and the expansion of delivery of PRSS. These and additional challenges were discussed as a group and are summarized in section E of this document.

## **Aligning Peer Recovery Support Services with Medication Assisted Treatment**

Zachary Talbot presented on his experiences working with peer support in OTPs. Mr. Talbot currently works in Tennessee as a Peer Recovery Specialist and has also worked in Georgia in a similar role. The state of Georgia provides certification for a Certified Peer Recovery Coach and services are eligible for reimbursement under the state Medicaid program, *PeachCare*. Tennessee, on the other hand, provides certification for a Peer Recovery Specialist but peer services are *not* eligible for reimbursement under the state Medicaid program, *TennCare*. Working in a peer capacity across state lines has proved challenging because of the lack of reciprocity and the variation in state credentialing requirements and reimbursement allowances.

In his early experiences working as a volunteer Peer Support Specialist in a North Georgia OTP, peer services were offered under the guidance of a Patient Advisory/Advocacy Committee. Mr. Talbot cited the following needs for advancing the peer role in MAT/MAR:

- Formal training for Peer Support Specialists, to ensure role clarity, qualifications, and practice standards;
- Clear definitions and distinction between peer support and peer advocacy;
- Design and implementation know-how, replication templates, and guidance from experienced and established PRSS/OTP programs, such as MARS;
- Other non-MAR PRSS programs and guidance documents, such as resources developed by CSAT's Recovery Community Support Program (RCSP).

## **Coalition Building and Community-based Peer Recovery Support Services**

Andre Johnson, member of SAMHSA/CSAT's National Advisory Council and President and CEO of the Detroit Recovery Project, Inc., shared three different examples of the integration of peer recovery support services. Each example was framed around the premise that community partnerships are paramount in the design and implementation of PRSS programs. The first example, Love Detroit Youth Coalition, consists of a partnership with Pharmacy Department and the Graduate School of Nursing at Wayne State University. One of its most visible activities was the display of billboard ads across the city to increase awareness of substance use disorders, as

well as health screenings. The Coalition also partners with the Drug Enforcement Agency (DEA) and local law enforcement agencies to host prescription “take-back” days, encouraging public safety through the safe disposal of prescription drugs.

In his second example, Mr. Johnson outlined the integration of PRSS with advocacy activities. This program is a partnership between the Detroit Police and Fire Departments, Wayne County Examiner’s Office, the Methadone Treatment Network, and the recovery community. One of the partnership’s advocacy activities was to provide 400 Naloxone kits to first responders as an overdose prevention strategy.

The third example provided was one of using peer services in treatment settings for social support by providing safe outlets and opportunities for meeting the four types of social support: emotional, informational, instrumental, and affiliation needs (Salzer 2002). More specifically, this model provides a non-judgmental environment for people in treatment and recovery where they can engage in healthy social activities in safe environments. Activities included a domino club and dancing, for example.

Mr. Johnson concluded with identifying future opportunities to enhance the use of PRSS including Medicaid funding, de-stigmatization, and the strengthening of relationships with allies.

### ***C. Perceived Contributions of Peer Recovery Support Services to Individuals***

After discussions within small groups, participants shared ideas about specific contributions PRSS could make to individuals enrolled in an OTP. Throughout the discussion, participants strategized to frame the contributions in ways to address skeptical attitudes that portray PRSS as ineffective or inappropriate to OTP settings. Participants identified several ways in which individuals achieved successful recovery through PRSS by accessing holistic wellness, hope, and recovery role modeling. It was suggested that PRSS can serve as a concurrent compliment to the clinical work that takes place in an OTP.

Participants noted several ways in which PRSS are beneficial, as identified below.

1. **Holistic wellness.** A PRSS program within an OTP promotes holistic wellness and offers recovery and life skills support.
2. **Guidance.** PRSS provide venues to advocacy, role modeling, and peer coaching, and provides direction and assistance in practical problem solving.
3. **Stigma reduction.** PRSS programs serve to reduce the stigma of medication-assisted treatment and recovery. Through education and advocacy, peer leaders raise awareness and understanding of addiction, treatment and recovery, not only individuals enrolled in an OTP but also for the client’s family and the community.

4. **Engagement and empowerment.** MAR PRSS providers demonstrate the authenticity of lived experience, and often have greater credibility with individuals in treatment and recovery. This can result in greater engagement and empowerment, as individuals relate through shared experiences and become confident in making good and informed decisions for themselves.
5. **Hope.** Being in contact with a successful peer role model is helpful to individuals enrolled in an OTP in seeing that they, too, are capable of achieving recovery. Peer providers are role models and provide living examples and hope that recovery can and does happen within a MAT environment.
6. **Buy-in.** More targeted research is needed in order to move PRSS from practice-based evidence to evidence-based practice. The ability to measure positive individual and program outcomes will result in increased buy-in from treatment professionals, policymakers, funders, and other stakeholders.
7. **Workforce Expansion.** PRSS providers can improve the client to staff ratio and allow clinicians to provide greater attention to MAT patients. Peer providers can also offer services outside of clinical settings, in various recovery community locations. Over time, individuals accessing MAR PRSS programs can be trained and become qualified to become PRSS providers.

#### ***D. Perceived Contributions of Peer Recovery Support Services to Organizations***

Participants discussed the specific contributions PRSS programs make to service entities such as OTPs, emergency rooms, health clinics, and doctor's offices. Citing the case for integrating PRSS programs into OTPs will involve strategies that are well-planned, presented, and documented. Financial considerations for implementing PRSS programs must also be clearly articulated, including budgeted costs and cost benefits. In addition, participants recommended that information about outcomes needs to be included when promoting PRSS, including improvements in client outcomes, resource-related benefits, and benefits to the perceived value of an organization within its community. These are further described below.

1. **Outcomes.** This can include measured client outcomes, such as treatment retention, improvement in access to and participation in social supports, improved family relationships, rates of employment, stable housing, etc., as well as program level measures. Participants suggested several outcomes of relevance to making a business case:
  - a. **Client activation into own wellness.** Peer recovery support services can increase an organization's engagement of clients in their own wellness, thereby increasing retention in treatment. This can result in an OTP being able to demonstrate both improved client treatment and recovery outcomes, and can be beneficial to the organization's finances.

- b. **Client satisfaction.** PRSS can result in greater client satisfaction with the care received at an OTP.
- c. **Quality of care.** PRSS programs can improve the quality of clinical and other care, and assist in supporting care coordination.
- d. **Support program functions.** PRSS can provide a variety of program functions within an OTP. For example, they can increase staff productivity by allowing clinical staff more time to provide clinical care. They can also increase treatment retention, and outcomes. PRSS can improve communication among staff, reduce barriers to seeking treatment, assist in health care enrollment, and improve the quality of services overall. This, in turn, can lead to an improved perception of clients by staff based on improvements made through PRSS. PRSS also serve to create a recovery-oriented culture change within an OTP, resulting in greater funding and the sharing and dissemination of successful programs.
- e. **Impact on clinical care.** PRSS may improve the effectiveness of OTPs by attracting funding as a result of improved outcomes achieved through program enhancements. PRSS may improve success/retention rates; increase more individuals with sustainable recovery, and assist individuals at critical clinical junctures for which “lived experience” is beneficial such as when medication dosages are tapered down through the course of treatment. Over time, long term outcomes can include the fact that individuals receiving services regain employment and contribute to society.

## 2. Resources.

### a. Financial.

- i. **Costs.** It is important to provide organizations information about Medicaid reimbursement for PRSS so that it is clear whether services are reimbursable and if so, exactly what is reimbursable. Equally important, OTPs need to investigate alternate funding streams to support PRSS programs.
- ii. **Cost effectiveness.** It is important to demonstrate the cost-effectiveness of PRSS programs within OTPs and the collateral benefits to other programs and components within the OTP.

### b. Human resources.

- i. **Staff retention.** As more PRSS programs are instituted in alignment with OTPs, it will be worthy to note if there is any residual effect on employee satisfaction and retention.
- ii. **Recognition of the value of peers.** The effectiveness of PRSS programs in OTPs will hopefully demonstrate that the use of peers has important benefits to the workforce and the field, providing unique support that is inappropriate for clinicians to provide.

## 3. Provide a bridge between organizations and communities (e.g., OTPs and other entities).

PRSS can connect individuals to professional and community resources outside of the OTP. This can include instrumental services like housing, employment, job

training, and education, as well as emotional and social supports necessary for sustainable recovery.

4. **Increase perceived value of the OTP in the community.** By working with the community in coordinating resources and building relationships with community organizations, PRSS programs can increase the perceived value and standing of the OTP within the community and can achieve positive public relations and greater visibility.

Despite these the beneficial aspects of PRSS programs at the organizational level, participants recognized that some opportunities to incorporate PRSS into OTPs may not be possible in all states, or even in all counties within a state. (For example, SAMHSA regulations do not specify how a clinic should be staffed but state agencies do specify staff ratios and it varies by state.) Any information and guidance offered to integrate PRSS needs to be reflective of specific state laws and policies.

### ***E. Challenges to Adding Peer Recovery Support Services to OTPs***

Several challenges to integrating PRSS programs into OTPs were identified throughout the discussion. Challenges ranged from medical and clinical staff not being sufficiently knowledgeable about peer services, to reimbursement and staffing concerns, to the lack of a solid research base. The challenges identified by meeting participants are described in greater detail below.

1. **Lack of knowledge or awareness about peer recovery support services.** PRSS may be viewed as “unnecessary” by OTPs, and physicians and other clinicians may not know that such services exist, are valuable, are reimbursable, or the specific contributions can be made by incorporating peer services. Furthermore, administrative and clinical staff has little working knowledge of how to design, plan, and implement a PRSS program.
2. **Conflicting philosophies of recovery and abstinence.** Many people still incorrectly think that MAT and MAR do not constitute abstinence-based recovery, because they see it as substituting one “drug” for another, rather than using prescribed medicine. The mindset of not being “in recovery” can also occur for individuals receiving MAT-- they have traditionally been encouraged think of themselves as being in recovery.
3. **Culture shift.** The movement towards recovery-orientation outlined and supported in the latest OTP guidelines from SAMHSA, will require a culture shift to help many in the OTP community to understand that, as one participant stated, “there is more to MAT than just the ‘T’”. OTPs have traditionally not been linked to the recovery community. This gap must be bridged, including overcoming the fear of change.
4. **Staffing.** Challenges in this category include certification, supervision, and education/training. Supervision may sometimes be done by an individual who is not a peer, sometimes a clinician who has received training in the foundational philosophies of PRSS and is familiar with peer practice. Clinical or other staff may oppose PRSS, due to fear of losing their jobs, having their turf invaded, and/or experiencing shifts in the

organization. In addition, the requirement of staff background checks are by state or accreditation regulations may pose a barrier for onboarding peer providers, many who have criminal justice histories as a result of their addiction.

5. **Costs.** As noted earlier, this is a particularly challenging area for incorporating PRSS programs into OTPs. Reimbursement availability varies by state, knowledge about using Medicaid to reimburse peer services is not widespread, organizations may see themselves as competing for the same funding and there are costs to clinics besides funding considerations. These include time, space, and other logistics of providing such services that OTPs may not be ready to operationalize or able to afford.
6. **Conflicting regulations.** Often, states and counties are faced with conflicting regulations. Current and existing regulations do not require PRSS. There is overall lack of support and management from the states. And certification of the peer role varies by state. Thus, there is no widespread standardization and a lack of reciprocal credentialing across states in most cases.
7. **Research.** To date, there is not a rich evidence base built on the research and evaluation of PRSS. Consequently, there is a lack of information in the field about the value, effectiveness, and cost-benefit of these services. Creating deemed status of PRSS as an evidence-based practice will help increase buy-in and promote widespread implementation of PRSS in OTPs.
8. **Other.** Other challenges identified by participants include:
  - a. Changing demographics of clients, in particular an older age group is seeking treatment, presenting challenges that programs have not had in the past.
  - b. Lack of client interest in anything besides obtaining their medications. Some clients do not want to interact or engage with the OTP beyond obtaining their dosage of medications, thus this group may be reluctant to engage in peer services.
  - c. Lack of understanding about the ideal settings in which peer services should be provided.

### III. Participant Recommendations/Actionable Items

As the meeting came to a close, participants were asked to discuss the question, “What would it take to increase the number of OTPs providing PRSS?” The recommendations from this final discussion are summarized below.

**Immediate Actions Item:** Develop and distribute a “Dear Colleague” letter from SAMHSA that makes a strong case for integrating PRSS into OTPs.

- a. This format is a nontraditional and creative approach that is efficient: it can be developed relatively quickly, it is brief and succinct and it can be disseminated to the OTP community without delay.

- i. Traditional Federal clearance processes associated with official guidelines would not apply to the “Dear Colleague” letter format
  - ii. The communication should take the form of a template that can be easily adapted from state to state
- b. Two national organizations representing two types of programs could be potential partners for SAMHSA in developing the “Dear Colleague” letter:
  - i. AATOD – American Association for the Treatment of Opioid Dependence (organization of Opioid Treatment Programs)
  - ii. Faces & Voices of Recovery/ Association of Recovery Community Organizations (ARCO)
- c. The document must include the following:
  - i. Information about the cost and benefits of integrating PRSS into OTPs
  - ii. Evidence about the effectiveness of PRSS
  - iii. Answers to frequently asked questions
- d. SAMHSA will provide the leadership by developing the document; state leaders and community organizations will then have impetus to work within states to move the recommendations forward.

### **Long-Term Recommendations:**

1. Initiate and encourage a transformative process towards recovery that is concurrently “top down” as well as “bottom up.”
 

This can be done by bringing together recovery providers and county- or municipal- level providers, where applicable. Incentives can be provided for collaboration and successes will reinforce continued participation and engagement. Disincentives could be implemented for NOT participating. The idea is that those offering PRSS will see better client retention and thus demonstrate good revenues in their bottom lines.
2. Work through the OTP accreditation bodies to revise OTP accreditation requirements to include provision of PRSS. Advocacy organizations can work with accreditation bodies to ensure that the requirements are included (and can explain why these services need to be broadly established/implemented in OTPs). Accreditation organizations can incorporate these standards without any federal mandate.
  - a. Approaching a change through federal guidelines is also feasible, but would require, at minimum, five years to implement since SAMHSA’s new OTP guidelines were released in 2015. As a way to back into the widespread integration of PRSS programs into OTPs, the six accreditation bodies for OTPs could be approached to include requirements for PRSS, since they traditionally incorporate additional best practices beyond what SAMHSA requires in their rules and regulations.
3. Provide better information about funding strategies to optimize the use of mental health and substance abuse block grants to support PRSS. Peer services are already provided for

in the block grants, but it is not codified or enforced. There needs to be a strong advocacy voice to promote funding for PRSS, while concurrently preserving funding streams for treatment. One state, Colorado has been successful in obtaining state funds for recovery.

4. Disseminate information to OTPs about the 1115 Medicaid waiver that includes peer support. The letter is available online at: <http://downloads.cms.gov/smsgov/archived-downloads/SMDL/downloads/smd081507a.pdf>
5. SAMHSA can wield influence through strategic incorporation of PRSS into upcoming FOAs. For example, SAMHSA can include PRSS as part of the next Medication Assisted Treatment-Prescription Drug and Opioid Addiction Request for Application (MAT-PDOA FOA). SAMHSA can include in the next FOA that grantee plans have to be inclusive of PRSS program implementation. Similarly, SAMHSA can include requirements in their FOAs to recovery community organizations (RCOs) that RCOs must work with emergency rooms. This two-fold approach would result in SAMHSA encouraging/ supporting each side (recovery, OTPs, healthcare) in working with each other to achieve collective impact.

## IV. Next Steps

The next steps include SAMHSA's development and dissemination of the "Dear Colleague" letter providing guidance to OTPs about the integration of peer recovery support services. In addition, there were five additional long term recommendations that may warrant further consideration or action. These include: 1) initiating a transformative process towards recovery, 2) revising OTP accreditation requirements to include the provision of peer recovery support services, 3) providing better information about using funds from the mental health and substance about block grants to support peer recovery support services, 4) disseminating information to OTPs about the 1115 Medicaid waiver that includes peer recovery support services support, and 5) incorporating PRSS into SAMHSA's upcoming FOAs. The participants also recommended that a subset of the group should reconvene soon to work more intensively on promoting the incorporation of PRSS into OTPs.



## Appendix A. Meeting Attendees

### Peer Recovery Support Services Meeting – SAMHSA CSAT

*September 28, 2015 at Gaithersburg, MD*

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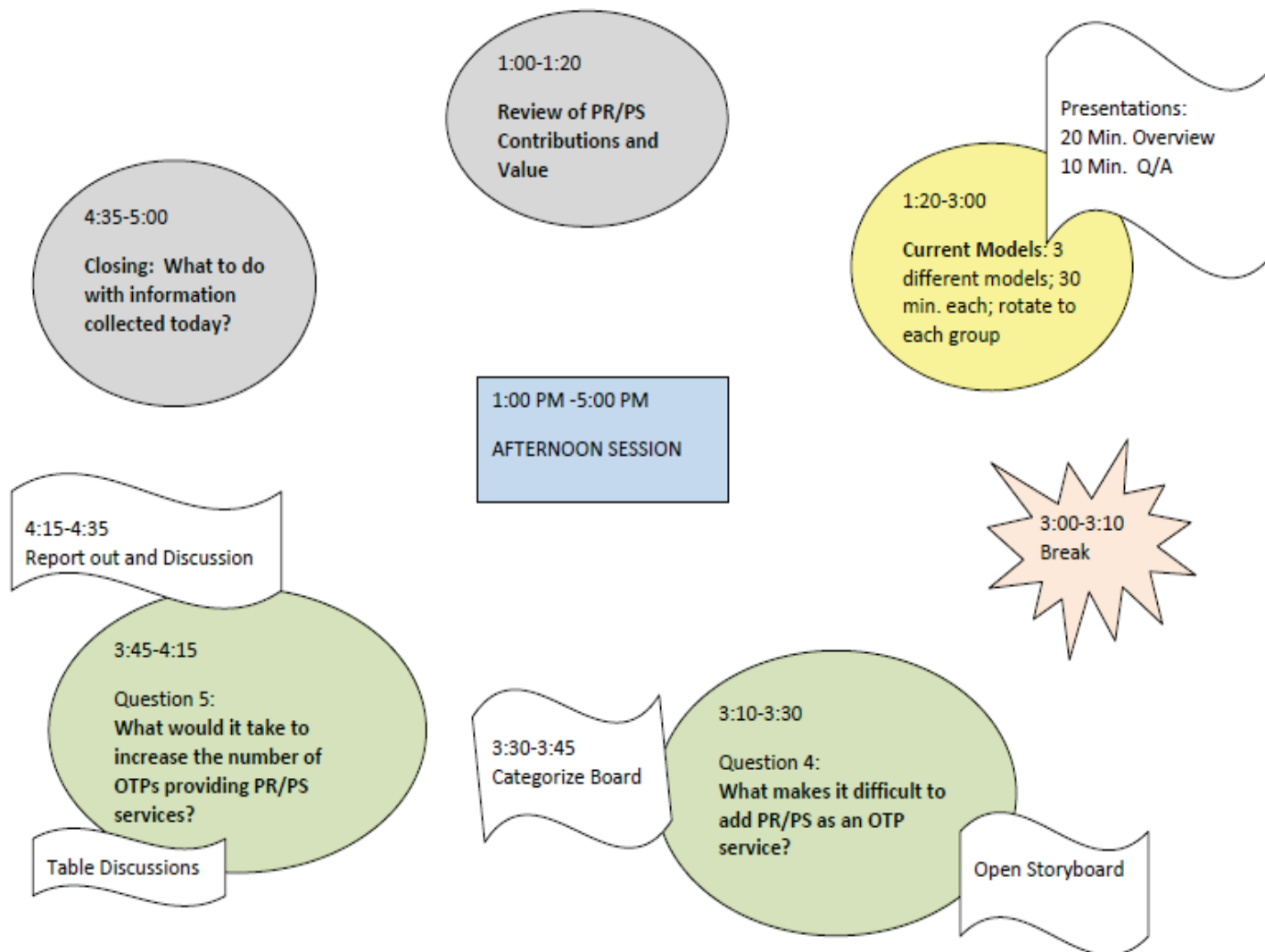
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## Appendix B. Meeting Agenda

### Peer Recovery Support Services Meeting – SAMHSA CSAT September 28, 2015 at Gaithersburg, MD







## Appendix C. Presentation: What are Peer Recovery/ Peer Support Services?

### PEER RECOVERY- PEER SUPPORT SERVICES and OTP's

September 28, 2015  
SAMHSA

### Peer Recovery Support Services...

- ...are designed and delivered by people who have experienced both substance use disorder and recovery.
- ...help people become and stay engaged in the recovery process and reduce the likelihood of relapse.

### What are Peer Recovery- Peer Support Services

MAKING OTP'S MORE  
RECOVERY FOCUSED

### Topics

- Holistic Definition of Recovery
- Biology and Stigma of Addiction and Addiction Medication
- How Peer Recovery Support Services Help



## What is Recovery?

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA

## Guiding Principles of Recovery

- ***Recovery emerges from hope***
- ***Recovery is person-driven***
- ***Recovery occurs via many pathways***
  - Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual.
  - Recovery pathways are highly personalized.
  - Recovery is non-linear.

## The “Recovery Community” Movement

- emphasizes recovery as an ongoing process of reengagement -- not merely abstinence from abused substances and
- emphasizes the active role of recovering people and their peers in recovery.

(White, W.L. 1996 & 2000)

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## Looking at Recovery and Strengths

- Bio-Psycho-Social (Holistic)
- Person-Centered

## Addiction Treatment -- Silos



## What is MARS™?

M = Medication  
A = Assisted  
R = Recovery  
S = Services

- The MARS™ Project is a peer-initiated and peer-based recovery support project sponsored by the National Alliance of Medication-Assisted (NAMA) Recovery.

## Treatment Efforts

- Medical Model
- Mental Health Programs
- Therapeutic Communities
- Faith Based Initiatives
- Criminal Justice

Funded through Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA)

A Recovery Community Support Program (RCSP) in 2006 MARS, 2010 MARS Center, 2011 Beyond MARS Training Institute, 2013 TCE-P to P MARS Expansion, 2014 BRSS – TACS Contract

1<sup>st</sup> project funded for Medication-Assisted Treatment (MAT) patients

1<sup>st</sup> recovery support project created and carried out by MAT patients themselves

## 2005 Was Time of Change for MAT and in Recovery

- There is an increased emphasis on the experience and engagement of the patients themselves.

(CSAT, 2005)

## Time of Change for MAT

- Emerging “best practices” in the field include:
  - education of patients
  - recognizing the strengths of patients and advocacy,
  - increasing engagement of patients treatment,
  - health and other service systems and
  - use of family and community supports

(CSAT, 2005)

## Challenges Where...

- Staff bear a large burden of administering medication and carrying out treatment activities mandated by funding sources, accreditation requirements, and Federal and State Regulations.
- Therefore, their ability to educate patients and provide individualized support is limited.

## Challenges

Relatively few clinic staff at any level have ever been MAT patients themselves.

- They often come from different backgrounds, many of which are openly antagonistic toward MAT.
- Few have any “I’ve been there” knowledge about the everyday world and challenges of being an MAT patient.



## Recovery Concepts

- William White portrays movement from addiction to recovery as a journey between two social worlds:
  - “addiction” and
  - “recovery”

## Slaying the Dragon

(White, W.L. 1996 & 2000)

## Recovery Concepts

- White sees recovery as a construct that emphasizes a reengagement with the community based on
  - Resilience
  - Health
  - Hope

(White, W.L. 1996 & 2000)

## Recovery Concepts

The “recovery community” movement

- emphasizes recovery as an ongoing process of reengagement -- not merely abstinence from abused substances and,
- emphasizes the active role of recovering people and their peers in recovery.

(White, W.L. 1996 & 2000)

## Recovery Values

The emerging movement emphasizes values that have clear value in MAT...

- maintaining an authentic voice for recovering people
- keeping recovery foremost
- leadership by recovering people
- engagement in other communities

## Recovery Values

These recovery concepts have rarely been applied to actual patient services in MAT.

MAT has been dominated by the professional staff that are needed to comply with regulations and licensing for use of a controlled medication.

MAT patients have had little opportunity to recognize their own strengths and that of their peers in seeking recovery.

## Peers in MAT

- People receiving MAT rarely even think of themselves as recovering people. They have not been allowed to.
- Traditional abstinence-based recovery organizations have ostracized methadone treatment and its patients primarily because of a view of methadone as a “substitute drug” or “crutch” in attaining sobriety.

## The MARS™ Project

- Meets patients’ needs for peer support
- Provides information about medication-assisted recovery

## PEER to PEER = Credibility

Many years of advocacy have shown us that when we as peers tell patients about treatment, and recovery, they believe us.

## PEER to PEER = Credibility

Not only have we been there...

... we are still there.

## MARS™

- The goal is to create a MARS™ recovery community for patients in MAT (Medication-Assisted Treatment)
- MARS™ provides peer support and information about medication, addiction, and recovery.

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## The Context for MARS™

- Approaches to Treating Addictions, Historically
- Treating the Whole Person
- Looking at Recovery and Social Support

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## Key Concepts

- Addiction is a bio-psycho-social disorder – it affects the whole person.
- MAT helps with the biology of addiction.
- Clinical staff can help with the psychology of addiction.
- The MARS™ peer community and other PRSS provides social support.

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## What Makes MARS™ Special

- Designed Specifically for MAT Patients
- Resources and Training Made Easy to Replicate

## Background

- When and where and how MARS™ was initiated
- Introduction of MARS™ at Einstein
- Estimated recovery groups and members
- Lessons learned so far

# MARS™ Programming

A Bio-Psycho-Social Approach

## Core Training Groups

Concrete knowledge and specific supports patients need to start and maintain recovery in MAT including:

- Methadone is Medicine
- Addiction – It's a Brain Disease
- What is Recovery?

## Biology of Addiction and How Addiction Medicine Works

Let's take a look at the brain...

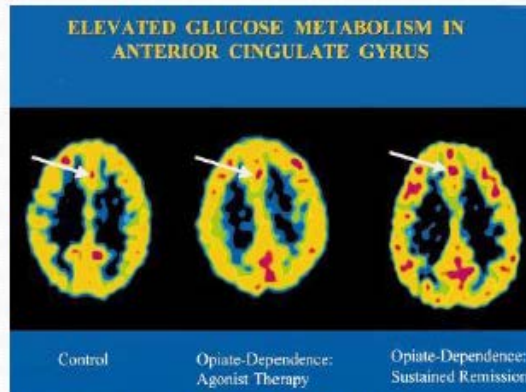
## Your Brain On Drugs



Science has come a long way in helping us understand how drugs of abuse effect the brain.



## This Is Your Brain on Drugs Today



Source: Galenker et al, 2000

## Other Informational Groups

Peers introduce varied topics for a “whole person” approach, such as

- General Health
- Stigma and Advocacy in the News
- Anatomy
- Anger Management
- Hispanic Group
- Women’s Group

## Spiritual Groups

Spiritual Recovery...

- Based on Methadone Anonymous

## Social Groups

- The MARS™ Community socializes in ways that are supportive of recovery...

- Book Club
- Arts and Crafts
- Chess
- Telling Your Story

## Peer Leadership

- What is a Peer Recovery Support Specialist?
- Ethics for Peer Leaders
- Group Facilitation Skills
- Stages of Change and Stages of Recovery
- Communication Skills
- Co-Occurring Disorders (COD)

## Events

Six drug-and-alcohol-free events are planned each year. They are designed to:

- get participants out of their daily routines
- enable them to socialize with each other
- rebuild social skills in a setting that is not centered around drugs or treatment
- foster and explore new interests

## Events

Events are chosen by peers...

Peers visited the Cloisters in NYC



## MARS™ Council

All MARS participants meet to discuss future:

- events
- groups
- anything relevant to the running and growth of their community

## Recovery Coaching

- Recovery Coaches Receive Sixty Hours of Training.
- Including 30hour CCAR Based Recovery Coach Academy
- 15 Hours of Ethics for Recovery Coaches
- 4 Hours of MAT for Recovery Coaches
- 11 Hours Practicum
- All coaches are certified by the NYCB (CAR

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## Recovery Coach Definition (from CCAR)

- A Recovery Coach is anyone interested in promoting recovery by removing barriers and obstacles to recovery by serving as a personal guide and mentor for people seeking or in recovery

Slide 1.14

## A Recovery Coach Is Not A . . . (Adapted from William White)

- Sponsor
- Counselor
- Nurse/Doctor
- Clergy Person

Slide 1.27

## Four Goals of a Recovery Coach

- Promote recovery
- Remove barriers
- Connect recoverees with recovery support services
- Encourages hope, optimism and healthy living

Slide 1.28



## MARS™ Programming

- MARS™ combines its emphasis on peer supports and reengagement with a parallel emphasis on understanding the nature of methadone itself.

How it works as a medication

Its solid roots in physiological aspects of opioid addiction and the medical bases for effective MAT

## Key Concepts

- MAT to MAR

***Turning Medication-Assisted Treatment  
into  
Medication-Assisted Recovery***

## The MARS™ Community

- Empowers patients
- Encourages retention in treatment
- Improves knowledge and attitudes toward treatment and recovery
- Provides a place where patients can participate openly, reducing stigma and isolation

## How to Implement MARS™

- In 2012, the *Beyond* MARS™ Training Institute was formed to replicate this model and implement MARS™ “satellite” programs across the United States.
- The Implementation Training provides all the instruction and resource materials needed. MARS™ will customize this training to meet the needs methadone programs, office-based practices, and free standing recovery centers.

## Implementation Training Shows

- **Staff** how they can support the patients' efforts
- **Patients** about the "science vs the stigma" of addiction, recovery and addiction medication
- **Everyone** how to create your own MARS™ community!

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## MARS Implementation Team Training

- MARS has been replicated 17 times in the US.
- MARS has just been replicated 4 times in Vietnam

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We look forward to  
working with you!



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From Sarah Church, Ph.D.

Exec Director, Division of Substance Abuse, Albert Einstein College of Medicine

"In 2006 Walter Ginter came to Einstein and we agreed that he would begin the MARS™ project in one of our MMTP programs. At that time, I thought we were providing recovery services. But, in retrospect, I realized I didn't understand what recovery was.

Over the past 8 years, I've come to understand that the work that we do in providing treatment to our patients will engage them for a few hours each week. The work that the MARS™ project does, engages them for all of the other hours that are not spent in treatment.

Once a patient stops using drugs, they no longer spend time getting money to buy drugs, seeking drugs, using drugs and recovering from drugs. MARS™ helps them to figure out how to spend all of that time in a positive way."

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# Appendix D. Presentation: Medicaid Reimbursement for Peer Support Services

## Medicaid Reimbursement for Peer Support Services

GINA ECKART  
HEALTH MANAGEMENT ASSOCIATES  
SAMHSA PEER SERVICES AND OTP FOCUS GROUP MEETING  
SEPTEMBER 28, 2015

## Medicaid Requirements for Peer Support Reimbursement

The Centers for Medicare and Medicaid Services (CMS) has provided guidance to states interested in offering peer support services within their service array

- Dear State Medicaid Director, August 15, 2007
  - Provides information on option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system.
  - Encourages collaboration between State Medicaid, Mental Health, and/or Substance Use Disorder Authorities to design service
  - State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.
  - States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies.
  - Reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care.
  - States must provide an assurance that there are mechanisms in place to prevent over-billing for services.

## Medicaid Reimbursement for Peer Support Services

There are several financing strategies available under Medicaid to fund Peer Support/Recovery Services

- 1905(a)
- 1915(b)-under managed care arrangements
- 1915(c)-as part of home and community based services waiver programs
- 1915i programs
- Section 2703 Health Homes
- 1115 Authority
- CCBHC Demonstration

## Additional CMS Requirements

### Providers

- Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders.

Supervision and care coordination are core components of peer support services.

- Supervision must be provided by a competent mental health professional
- Peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals

Peer support providers must be sufficiently trained to deliver services.

- Peer support providers must complete training and certification as defined by the State.
- Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function.
- The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders.

## States Successes with PRSS

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**Massachusetts** Department of Health, Bureau of Substance Abuse Services recognized the importance of sustainability and building the business case for PRSS, and funded a network of peer recovery support centers following a system review and reprioritization of services and funding.

In **Georgia**, the State developed and integrated PRSS, utilizing peers referred to as CARES (certified addiction recovery empowerment specialist), within its delivery system by using a model from the mental health field that ensured Medicaid funding.

The **Indiana** Division of Mental Health and Addiction and the Indiana State Department of Health have jointly approved a training and certification process for the Indiana Integrated Care Community Health Worker (CHW) and Certified Recovery Specialist Program (CRS). Persons in recovery from a gambling or substance abuse disorder are eligible to apply for the G and/or SA Endorsement after completing the CHW/CRS designation.

**Arizona's** Community Bridges, Inc., an FO, employs 300 peer leaders in a variety of worksites, attracting funding from multiple sources.

Source: [http://www.williamwhitepapers.com/pr/file\\_download.php?fn=CSAT+Perspectives+on+Peer+Recovery+Support+Services+2013&ext=pdf](http://www.williamwhitepapers.com/pr/file_download.php?fn=CSAT+Perspectives+on+Peer+Recovery+Support+Services+2013&ext=pdf)

## Additional Information

### State Medicaid Director Letter

<http://downloadscms.gov/cmsgov/archiveddownloads/SMDL/downloads/smd081507.pdf>

### National Overview of Peer Support Training Programs (2012)

<http://www.dbsalliance.org/pdfs/training/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview%20UT%202013.pdf>

Source: [http://www.williamwhitepapers.com/pr/file\\_download.php?fn=CSAT+Perspectives+on+Peer+Recovery+Support+Services+2013&ext=pdf](http://www.williamwhitepapers.com/pr/file_download.php?fn=CSAT+Perspectives+on+Peer+Recovery+Support+Services+2013&ext=pdf)

## Challenges to Peer Support Reimbursement

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CSAT Recovery Community Support Program's (RCSP) Peer Recovery Support Services held a two day consultation meeting in September 2012

- Challenges identified in providing peer support were:
  - maintaining an authentic peer recovery role
  - gaining acceptance by clinicians
  - **obtaining adequate funding** and outcomes data
  - collaborating and integrating PRSS with other service systems
  - ensuring adequate peer leader training and supervision
  - maintaining advocacy support
  - determining the best locus for PRSS delivery
  - developing links with other key organizations such as Federally Qualified Health Centers to expand delivery of PRSS

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## Appendix E. Presentation: Peer Support Services in Medication Assisted Treatment for Opioid Addiction

### Peer Support Services in Medication Assisted Treatment for Opioid Addiction

*A southern experience in peer support services through a methadone maintenance treatment program.*



## What is an Opioid Treatment Program (OTP)?

- The terms Opioid Treatment Program (OTP) and Narcotic Treatment Program (NTP) are often used interchangeably in the field
- OTP = “Methadone Clinic”
- Many argue that referring to OTPs as “methadone clinics” is not accurate because...
  - Methadone (Dolophine™, Methadose™) is just one of several medications dispensed as part of an overall treatment program – OTPs also can dispense buprenorphine (Subutex™), buprenorphine/naloxone (Suboxone™, Zubsolv™, Bunavail™), naltrexone (Vivitrol™)
  - The medication is just one part of a comprehensive treatment approach – OTPs also offer individual counseling, group therapy, medical care (annual physical examinations, testing and/or treatment for Hepatitis C and/or HIV, etc.), drug testing, peer support services and some offer mental health services in house – ALL refer for mental health and other medical care
- Highly structured, highly regulated, comprehensive treatment centers

## The Peer Support Specialist...

- The Peer Support Specialist can also be known as a...
  - Peer Coach
  - Recovery Coach
  - Peer Recovery Coach
  - Peer Support Worker
  - Peer Recovery Specialist
- There are several interchangeable titles for the Peer Support Specialist, but their focus and primary responsibilities are the same.





## As a Volunteer Peer Support Specialist in a North Georgia OTP...

- At first found there to be difficulties in setting standards due to lack of formal training for peer support specialists in the area
  - Individuals, including myself, who initially began to serve as peer supporters/recovery coaches drew legitimacy through our experience and “real world” knowledge
  - Though some of us had formal education and/or training in behavioral health, none of it was specific to peer support services
  - There were no real organizational models to turn to for support like iNAPS or the MARS Project

## As a Volunteer Peer Support Specialist in a North Georgia OTP...

- Peer support services, though we didn’t really call them that or have a title, started being offered under our Patient Advisory/Advocacy Committee
- Peer support quickly became one of the primary focuses of our volunteer crew, and we were faced with trying to define what we were doing, what we offered, and the differences and similarities between peer support and advocacy – there was NO guidance
- Things like helping patients new to recovery find jobs, vocational training, go back to school (get old loans out of default), etc. began to take up significantly more time than the advocacy tasks we initially thought – like dealing with Child Protective Services, Parole/Probation Officers, etc.

## CSAT’s Recovery Community Support Program

- CSAT’s RCSP identifies four types of recovery support services:
  1. Emotional Support
  2. Informational Support
  3. Instrumental Support
  4. Companionship

## The Peer Support Specialist...

### ...is

- Outreach worker
- Motivator and Cheerleader
- Planner
- Resource Broker
- Monitor
- **Advocate**
- Educator
- Life Coach
- Problem Solver

### ...is NOT

- **Sponsor**
- **Therapist/Counselor**
- **Nurse/Physician**
- **Priest/Rabbi/Pastor/Imam (Clergy)**

# Peer Support Certifications and Re-imbursement

## GEORGIA

- Certification as a “**Certified Peer Recovery Coach**” through the Georgia IC&RC Chapter, reciprocal credential
- Primarily mental health focus thus far, but not exclusive to mental health
- Services eligible for reimbursement under “PeachCare,” Georgia’s Medicaid program
- More info: <http://www.adacbga.org/apps-manuals/CPRC-Requirements-Application-rev-2014-05-22.pdf>

## TENNESSEE

- Certification as a “**Certified Peer Recovery Specialist**” through the State of Tennessee’s own program, no automatic reciprocity
- Heavy abstinence-based substance use focus thus far
- Services **NOT** eligible for re-imbursement under “TennCare,” Tennessee’s Medicaid program
- More info: <https://www.tn.gov/behavioral-health/topic/certified-peer-recovery-specialist-program>

## FOR MORE INFO....

- **Peers for Progress:** <http://peersforprogress.org/>
- InterNational Association of Peer Supporters (**iNAPS**): <http://inaops.org/>
- **The Joint Commission’s** Webinar (replay) on standards for Peer Support Services in Accreditation: [http://www.jointcommission.org/webinar-replay\\_peer\\_services\\_bhc/](http://www.jointcommission.org/webinar-replay_peer_services_bhc/)
- The Medication Assisted Recovery Services (**MARS**)™ Project: <http://www.marsproject.org/>

# Appendix F: Presentation: Integration Peer Recovery Services

## Love Detroit Youth Coalition

- Bill Board Ads
- Partnership with Wayne State University (Pharmacy Dept & Graduate School of Nursing)
- Funded by Partnership for Success

## Peer Recovery Peer Services Meeting

SAMSHA ~  
1 Choke Cherry  
Rockville, Maryland

## EXAMPLES OF INTEGRATING PEER RECOVERY SERVICES

- COALITION ~ Mike/ Long-Term Recovery
- ADVOCACY ~ Deborah/Long-Term Recovery
- PEER SUPPORT SERVICES ~ Uncle Dave/Long-Term Recovery

## Advocacy

- All peer board of directors
- SBIRT
- PARTNERSHIP
  - ✓ DETROIT POLICE DEPARTMENT
  - ✓ WAYNE COUNTY EXAMINERS OFFICE
  - ✓ FIRE DEPARTMENT
  - ✓ METHADONE TX NETWORK – ALLIES
  - ✓ RECOVERY COMMUNITY (ALL 12-STEP SUPPORT GROUPS)
- Naloxone
  - ✓ 400 KITS
  - ✓ EVIZIO SELF-INJECTORS
  - ✓ KALEO PHARMACY

## Recovery Services

- Uncle Dave
- Fellowship Anonymous
- SOCIAL SERVICES
  - ✓ DOMINO CLUB
  - ✓ DANCING
  - ✓ NON JUDGEMENTAL ENVIRONMENT

HOPE

ANYONE CAN LOSE THE DESIRE TO USE ILLEGAL  
DRUGS AND FIND A NEW WAY OF LIFE

## Future Opportunities

- Medicaid Funded
- DESTIGMATIZATION
- ALLIES RELATIONSHIP STRENGTHEN

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